



Toll Free: 1-800-276-7619, Ext. 4264

AssureLINK Address: <http://assurelink.assurity.com>

California Application for Critical Illness Insurance

This application includes all forms needed to apply for Critical Illness Insurance.

This application does not include the Life or Disability Income section(s).

Thank you for your interest in writing business with Assurity Life Insurance Company.

You may write a Life or Disability Income application* in combination with this Critical Illness application. In addition to this application, simply complete the appropriate Life or Disability Income section(s) obtained from AssureLINK or from a Life or Disability Income application. The advantages of writing a combined application are:

- answer medical questions once
- reviewed by Underwriting once
- scheduling one medical exam
- achieve two/three sales with one visit

To enable us to process your application more quickly, please review the following checklist:

- ✓ For Disability Income and Critical Illness products, the application should coincide with the **state in which the policy Owner resides** for the states listed below. (For Disability applications, the Proposed Insured and the policy Owner must be the same person.)

Disability Income (Form A-D109): CA, FL

Simplified Critical Illness (Form CI 005): AR, CO, FL, ID, ME, MN, MT, NH, NC, ND, OK, PA, UT, WV

Critical Illness (Form CI 007): AR, ID, ME, MT, NC, ND, OK, PA, UT, WV

All other applications should coincide with the **state where the application is signed**. State specific applications and state forms can be found on AssureLINK.

- ✓ To comply with state regulations and protect your interest, you must be properly licensed and appointed by Assurity **in the state coinciding with the application used**.
- ✓ Print the application in black ink for faxing and photocopying purposes.
- ✓ Please verify that all questions on the application are answered. Obtain all required signatures.
- ✓ Have the Proposed Insured initial any changes. (Corrections with white correction fluid/tape are not acceptable.)
- ✓ Comply with all state regulations
 1. NAIC Model Illustration or disclosure statement must accompany any whole life application.
 2. Complete all other pertinent and applicable forms padded together in this application.

If faxing an application directly to the Home Office, fax to (877) 864-6630.

- ✓ If mailing directly to the Home Office, address to:
Assurity Life Insurance Company
Attn: New Business Unit
PO Box 82533
Lincoln NE 68501-2533

TO CHECK THE STATUS OF AN APPLICATION, ASK QUESTIONS RELATING TO UNDERWRITING (INCLUDING "WHAT IF" SCENARIOS) CALL TOLL FREE 800-276-7619, EXT. 4264 OR EMAIL TO underwriting@assurity.com.

Insurance Application to Assurity Life Insurance Company

California law prohibits an HIV test from being required or used by health insurance companies as a condition of obtaining health insurance coverage.

PART 1 – General Section

I hereby apply for insurance with Assurity Life Insurance Company to be issued in reliance upon the following statements which I represent to be complete and true to the best of my knowledge and belief:

1. A. Full First Name (Please Print) Middle Initial Last Name		B. Social Security # - -		C. Sex <input type="checkbox"/> M <input type="checkbox"/> F
D. Date of Birth Mo. Day Year / /	E. Age Nearest birthday	F. Height Weight ft. in. lbs.	G. Weight change in past year lbs. <input type="checkbox"/> loss <input type="checkbox"/> gain	H. Birth State
2. A. Residence: Street and No. City State Zip Code				
B. Proposed Insured's home phone number			Best time to call Proposed Insured	
3. A. Occupation and duties (including those pertaining to any part-time occupation) Occupation: Duties:		B. Employer and address C. How long employed?		D. Gross average Monthly income (if not self-employed) If self-employed, net monthly income:

4. Do you belong to any National Guard or military? Yes No
If "yes," please explain: _____
5. Has any person to be covered flown during the last 5 years as a pilot, student pilot or crewmember? Yes No
If "yes," please complete the Avocation Questionnaire.
6. Has any person to be covered participated during the last 3 years in any hazardous sports or activities such as motor vehicle or boat racing, sky diving, skin or scuba diving or any such related activities? Yes No
Are any such activities contemplated? Yes No
If "yes," please complete the Avocation Questionnaire.
7. Do you contemplate residence or travel outside of the United States for more than 60 days within the next year? Yes No
If "yes," please explain: _____
8. Within the last 5 years, have you or to your knowledge has any person to be covered:
A. Had life, health, or hospital expense insurance postponed, rated up, ridered, declined or had renewal or reinstatement refused? Yes No
B. Received benefit payments for accident or sickness or applied to any government or insurance organization for such benefits? Yes No
If either A or B is answered "yes," please explain: _____
9. If this insurance is issued, will it replace any insurance, annuity or other policy? Yes No
If "yes," please complete: Policy Number: _____
Name and address of company being replaced _____
(Send the State replacement forms with application.)
10. Are you negotiating for other insurance coverage?..... Yes No
If "yes," please explain: _____
11. Has the Proposed Insured ever used any form of tobacco or nicotine-based products? Yes No
If "yes," when did the Proposed Insured last use tobacco or nicotine-based products? Date: _____
12. Driver's license number: _____
Has any person to be covered received any citations within the last 5 years for motor vehicle moving violations or had a driver's license suspended or revoked? Yes No
If "yes," please explain: _____

Part 1 – General Section (Cont.) If medical exam required due to age and/or amount, you may omit answering questions 14-19 on Proposed Insured.

13. Names of dependent Children (who have not reached their 19th birthday) proposed for Children's Term Insurance Rider. **(Note: Please complete 14-17 for any children to be covered.)**

Full Name	Relationship	Birthdate	Age	Height	Weight lbs.	Residing w/Insured?	Name/Address of Physician
						Yes <input type="checkbox"/> No <input type="checkbox"/>	
						Yes <input type="checkbox"/> No <input type="checkbox"/>	
						Yes <input type="checkbox"/> No <input type="checkbox"/>	
						Yes <input type="checkbox"/> No <input type="checkbox"/>	

14. Have any persons to be covered ever been treated for, been hospitalized for, or been positively diagnosed by a member of the medical profession as having any of the following? *If "yes," circle condition(s) and complete #16 below.*

- A. Dizziness, fainting spells, epilepsy, depression, anxiety, mental disorder, or any disease or disorder of the brain or nervous systems? Yes No
- B. Asthma, bronchitis, tuberculosis, pneumocystis, or any disorder of the lungs or respiratory system? Yes No
- C. High blood pressure, chest pain, shortness of breath, heart murmur, rheumatic fever or any disease or disorder of the heart, hemophilia or coagulation disorder? Yes No
- D. Any disease or disorder of the stomach, intestines or bowel, rectum, appendix, liver or gall bladder? Yes No
- E. Any disease or disorder of the kidney, bladder or prostate? Yes No
- F. Arthritis, rheumatism, or any disease or disorder of the back, spine, bones, joints, or muscles? Yes No
- G. Diabetes, or sugar, albumin or blood in the urine? Yes No
- H. Cancer or a tumor or cyst of any kind, or enlargement of lymph nodes? Yes No
- I. Varicose veins, varicose ulcer or phlebitis, syphilis, or a hernia? Yes No
- J. Any disease or disorder of the eyes, ears, nose or throat? Yes No
- K. Any advice or treatment for alcoholism, drug addiction, drug abuse or other substance abuse? Yes No
- L. Any other illness or injury requiring blood transfusion or other medical attention? Yes No
- M. Any special examinations or laboratory tests such as X-rays, electrocardiograms, blood tests other than AIDS related blood tests, or urine tests during the past 5 years? Yes No
- N. has the Proposed Insured been diagnosed as having or been treated for ARC or AIDS?..... Yes No

15. If any questions in 14 are answered "yes," indicate the question number and give complete details. **If additional space is required, attach a separate page signed by the Proposed Insured.**

No.	Name of Person	Condition	Onset Date	Duration	Names, Addresses and Phone #'s of all Physicians, Hospitals and Medical Facilities

17. Name, address and phone # of Proposed Insured's regular physician: Fax: Phone:	Date last consulted:
	Reasons and results:

18. Family History: Has any of your immediate family members (parents, brothers, or sisters) died from cancer, diabetes or cardiovascular disease prior to age 60? Yes No
 If "yes," identify family member, disorder, and age at death below:

For Life Policies Only

- 19. A. In the past 5 years, has any person to be insured had any complication of pregnancy or delivery, miscarriage, stillbirth or Cesarean section? Yes No
- B. Is any person to be insured now pregnant? If "yes," give date child is expected: _____ Yes No

Part 2 – Critical Illness Section - California Insurance Law requires that You, the Proposed Insured, are covered by an individual or group contract that arranges or provides comprehensive health insurance or HMO plan including medical, hospital and surgical coverage to be eligible to purchase a specified disease policy. Are You, the Proposed Insured, currently insured for comprehensive health care?
 Yes No **IF YOUR ANSWER IS NO, YOU ARE NOT ELIGIBLE TO APPLY FOR THIS POLICY.**

20. Name of spouse and/or dependent children (who have not reached their 19th birthday) proposed for coverage under the Spouse and/or Children's Rider. (Part 1 – General Section questions 11, 15-17 and 19 apply.)

Full Name	Relationship	Sex		Date of Birth	Age	Height	Weight	Residing with Proposed Insured	
		M	F					Yes	No
_____	Spouse	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
_____	Child	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
_____	Child	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>

21. To the best of your knowledge, have any persons to be covered ever had symptoms of, been treated for, been advised to receive treatment, have had any investigation, been hospitalized for, or been positively diagnosed by a member of the medical profession as having any of the following? If "yes," complete #22 below.

- | | Yes | No |
|---|--------------------------|--------------------------|
| A. Heart attack, stroke, elevated or abnormal cholesterol, angina, coronary heart disease, disease of the blood vessels or TIA (Transient Ischemic Attack)? | <input type="checkbox"/> | <input type="checkbox"/> |
| B. Thyroid disorder, hepatitis, hepatitis carrier, anemia, fatigue, disorder of the pancreas, any lupus or any other blood or glandular disorder? ... | <input type="checkbox"/> | <input type="checkbox"/> |
| C. Polyp, mole, lump, other growth, breast disorder, abnormal mammogram or biopsy or abnormal PSA test? | <input type="checkbox"/> | <input type="checkbox"/> |
| D. Have you ever used marijuana or any illegal or addictive drugs? | <input type="checkbox"/> | <input type="checkbox"/> |
| E. Do you regularly take any medications (specify type and dosage)? | <input type="checkbox"/> | <input type="checkbox"/> |
| F. Have you ever consulted any Physician within the last five years for which details are not given above? | <input type="checkbox"/> | <input type="checkbox"/> |
| G. Have you been advised to have surgery, treatment or testing, which has not been completed (excluding HIV tests)? | <input type="checkbox"/> | <input type="checkbox"/> |

22. If any questions in #21 are answered "yes," indicate the questions letter and give complete details. **If additional space is required, attach a separate page signed by the Proposed Insured.** Details of all "Yes" answers for Question 21.

No.	Details

23. To the best of your knowledge, has any immediate family member (whether living or deceased) ever suffered from, or is suffering from cancer (specify type), heart disease, stroke, kidney disease, diabetes, amyotrophic lateral sclerosis (ALS or Lou Gehrig's Disease), motor neuron disease, Alzheimer's Disease, Parkinson's Disease or any other hereditary disease prior to age 65? (If "Yes," please complete the chart below.)

Person Proposed for Insurance	Family Member/ Relationship	Diagnosis	Age at Time of Diagnosis

24. Plan: Critical Illness Premium Payment Method: <input type="checkbox"/> Annually <input type="checkbox"/> Quarterly <input type="checkbox"/> Semi-Annually <input type="checkbox"/> Monthly <input type="checkbox"/> Other _____	Benefit Amount: \$ _____ Amount Collected: \$ _____	25. Optional Benefits <input type="checkbox"/> Accidental Death Benefit \$ _____ <input type="checkbox"/> Children's Rider <input type="checkbox"/> \$5,000 <input type="checkbox"/> \$10,000 <input type="checkbox"/> Return of Premium <input type="checkbox"/> Spouse Rider Benefit Amount \$ _____ <input type="checkbox"/> Waiver of Premium
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26. The Primary Beneficiary (name and relationship) who survives the Proposed Insured: _____

27. Do you have any other Critical Illness insurance? Yes No If Yes, please indicate the name and address of the Company and the Policy Number: _____

I AGREE THAT

- A. I have read the above questions and answers and declare that they are complete and true to the best of my knowledge and belief. I agree that this application (Part 1 – General Section pages 1 & 2, Part 2 – Critical Illness Section and Answers Made to the Medical Examiner if required) shall form a part of the policy if attached thereto.
- B. In the event the first full premium on the policy I have applied for is paid on the date of this application, the insurance under the policy shall take effect as provided in the Conditional Receipt and delivered by the Company's agent in exchange for the payment.
- C. In the event the first full premium on the policy I have applied for is not paid on the date of this application, the insurance under the policy shall not take effect unless the application is approved by the Company at its Home Office, the policy is issued and delivered to Proposed Insured/Owner, and the first full premium paid during the Proposed Insured's lifetime and continued good health, and when the approval, issue, delivery and payment have occurred, the insurance under the policy shall take effect as of the date of issue stated in the policy.
- D. No agent or medical examiner is authorized to change or waiver any term, provision or condition of this application, the Conditional Receipt, or the policy I have applied for, or to pass upon or approve insurability of any person for whom insurance is applied for.

Signed at _____ this _____ day of _____, Year _____.

Witnessed by _____
Licensed Resident Agent Signature of Proposed Insured

Agency No. _____

Field Underwriter's Statement

1. A. What amount was collected with this application? \$ _____
- B. Has a Conditional Receipt been given to the Proposed Insured/Owner? Yes No
- C. Has an Authorization for Release of Medical Information been signed and Fair Credit and M.I.B. notification been given? Yes No
2. A. Did you personally see all persons to be insured on date of application? Yes No
If "No," please explain in #7.
- B. How well do you know Proposed Insured? Well Slightly Relative Not at all
- C. Are you aware of anything about the health, habits, hobbies or mode of living which might affect the insurability of the Proposed Insured? Yes No
If "Yes," please explain in #7.
- D. Is the Proposed Insured a citizen of the United States? Yes No
If "No," provide type of visa, number, and expiration date below:
- _____

3. Is application being submitted on a non-medical basis? Yes No
If "No," check items for which arrangements have been made:
- Medical exam by physician with Home Office specimen Blood Profile EKG Chest X-ray
- Paramedical examination with Home Office specimen* Dried Blood Profile Blood Profile EKG
- *Preferred Plus and Preferred underwriting classifications require blood profile, not dried blood spot.

Name and address of examiner _____

Date above items to be completed _____

4. All Life cases require a signed illustration be submitted with the application or a signed Illustration Disclosure Statement. The Premiums for this application were quoted on the following underwriting classification:
- Preferred Plus Preferred Select (standard, non-tobacco) Tobacco
5. If this insurance is issued, will it replace any insurance, annuity or other policy? Yes No
If "Yes," please explain in # 7.

6. I hereby certify that to the best of my knowledge and belief the answers on the application and in this statement are true and correct.

Soliciting Agent Signature	Code No.	Date _____	Year _____
Soliciting Agent Printed Name	Agent Business Phone #	Agent Fax #	

7. Special requests, remarks and instructions:

Was this application faxed to the Home Office? Yes No
If yes, date faxed _____

8. **Referrals** Name: _____
Name: _____

9. Pre-Authorized Check (PAC) – Special monthly rate is 8.8% of annual premium.
- New PAC Signed authorization and deposit ticket needed with application. Applications and/or policy numbers _____ to be included on this PAC.
- Add to existing PAC on: _____
- List Billing Set up new list billing - complete Employer's Authorization and Case Agreement (form VBDIEA-97)
- List Billing Add to existing billing # _____ to: Name of Company _____

For Home Office use only: Date received _____ Policy # _____ CWA \$ _____



Name of Applicant/Insured/Claimant (Please print)

_____/_____/_____
Date of Birth (MM/DD/YYYY)

Name of Additional Applicant/Insured/Claimant (Please print)

_____/_____/_____
Date of Birth (MM/DD/YYYY)

Applicant/Insured/Claimant Child(ren)			
<i>Name</i>	<i>Date of Birth</i>	<i>Name</i>	<i>Date of Birth</i>
_____	_____	_____	_____
_____	_____	_____	_____

I, on behalf of myself or the person named above (*Individual*), authorize any licensed physician, medical practitioner, hospital, clinic, pharmacy or pharmacy benefit manager, records custodians, other medical or medically related facility, insurance or reinsurance company, the Medical Information Bureau (*MIB*), consumer reporting agency, employer or medical organization or person that has any records or knowledge of the Individual or their health to disclose to Assurity Life Insurance Company (*Assurity*), its reinsurers and/or consumer reporting agencies and their authorized representatives (*provided, however, consumer reporting agencies may not collect information under this authorization from the MIB*):

- Information as to diagnosis, treatment and prognosis pertaining to medical history, mental or physical condition, pharmacy and/or prescription drug records, or treatment and information pertaining to mode of living (*except as may be related directly or indirectly to sexual orientation*), occupation, finances, avocations and other characteristics.
- Information on the diagnosis or treatment of human immunodeficiency virus (*HIV*) infection and sexually transmitted diseases (**Except information about human immunodeficiency virus (*HIV*) infection for Individuals residing in Maine or Vermont.** **For residents of Maine:** this authorization excludes disclosure of the results of a test for HIV if the Individual has tested HIV positive but has not developed symptoms of the disease AIDS. Such test results shall not be discovered or published. Nothing in this caveat will prohibit this authorization from including the fact that the Individual has AIDS. **For residents of Vermont:** this authorization excludes the release of any information about previously administered tests for HIV antibodies, T-cell counts, AIDS or ARC. The Individual is NOT authorizing Assurity to forward the results from any new test requested by Assurity to any outside, non-affiliated company or any entity not under specific contract to perform underwriting services.
- Information on diagnosis and treatment for alcohol, drug and tobacco use, and mental illness. Excluded are psychotherapy notes, but included are medication prescription and monitoring, counseling session start and stop times, the modalities and frequencies of treatment furnished, results of clinical tests and any summary of the following items: diagnosis, functional status, treatment plan, symptoms, prognosis and progress to date.
- Information provided on applications to obtain driving records and credit information. The records obtained will be used to determine eligibility for insurance, including additional coverage to an existing policy. I authorize the release of any information contained in credit reports and driving records, including but not limited to information on motor vehicle accidents and/or violations.

I understand that this information may be released by Assurity and/or its reinsurers to their consulting physicians, their attorneys, the MIB and to other insurance companies in which the Individual has policies or to whom applications may be made, or to whom claims for benefits have been made or may be submitted.

By my signature below, I acknowledge that any agreements I have made to restrict protected health information of the Individual do not apply to this authorization, and I instruct any licensed physician, medical practitioner, hospital, clinic, pharmacy or pharmacy benefit manager, records custodians, other medical or medically related facility, insurance or reinsurance company, the Medical Information Bureau (*MIB*), consumer reporting agency, employer or medical organization or person that has any records or knowledge of the Individual or their health to release and disclose the Individual's entire medical record as described above without restriction. The medical information so acquired will be used to determine eligibility for insurance, including additional coverage to an existing policy and/or eligibility for benefits under a policy. I understand that this information may be subject to re-disclosure by Assurity and may no longer be protected by the federal rules governing privacy of health information, and that this information may only be redisclosed in accordance with other applicable laws or regulations.

This authorization is valid for twenty-four (24) months from the date of signature below (**Except for residents of Arizona, authorization to disclose HIV-related information is valid for 180 days from the date of the signature below**), for collecting information in connection with an application for an insurance policy, policy reinstatement or claim. A copy of this authorization is as valid as the original. I understand that I, or my authorized representative, will receive a copy of this authorization if requested. I understand that I have the right to revoke this authorization at any time by providing written notice to Assurity. I understand that a revocation is not effective to the extent that action has been taken in reliance on this authorization. I further understand that if I refuse to sign this authorization, Assurity may not be able to process this application, or if coverage has been issued, may not be able to make any benefit payments.

This authorization complies with the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule.

Date (MM/DD/YYYY)

Signature of Applicant/Insured/Claimant, Legal Representative or Parent of Child(ren) under age 18

Signature of Additional Applicant/Insured/Claimant or Legal Representative

Signature of Applicant/Insured/Claimant Child (if age 18 or older)

Description of Legal Representative's Authority for Applicant/Insured/Claimant (please indicate which Individual is represented)





Name of Applicant/Insured/Claimant (Please print)

_____/_____/_____
Date of Birth (MM/DD/YYYY)

Name of Additional Applicant/Insured/Claimant (Please print)

_____/_____/_____
Date of Birth (MM/DD/YYYY)

Applicant/Insured/Claimant Child(ren)			
<i>Name</i>	<i>Date of Birth</i>	<i>Name</i>	<i>Date of Birth</i>
_____	_____	_____	_____
_____	_____	_____	_____

I, on behalf of myself or the person named above (*Individual*), authorize any licensed physician, medical practitioner, hospital, clinic, pharmacy or pharmacy benefit manager, records custodians, other medical or medically related facility, insurance or reinsurance company, the Medical Information Bureau (*MIB*), consumer reporting agency, employer or medical organization or person that has any records or knowledge of the Individual or their health to disclose to Assurity Life Insurance Company (*Assurity*), its reinsurers and/or consumer reporting agencies and their authorized representatives (*provided, however, consumer reporting agencies may not collect information under this authorization from the MIB*):

- Information as to diagnosis, treatment and prognosis pertaining to medical history, mental or physical condition, pharmacy and/or prescription drug records, or treatment and information pertaining to mode of living (*except as may be related directly or indirectly to sexual orientation*), occupation, finances, avocations and other characteristics.
- Information on the diagnosis or treatment of human immunodeficiency virus (*HIV*) infection and sexually transmitted diseases (**Except information about human immunodeficiency virus (*HIV*) infection for Individuals residing in Maine or Vermont.** **For residents of Maine:** this authorization excludes disclosure of the results of a test for HIV if the Individual has tested HIV positive but has not developed symptoms of the disease AIDS. Such test results shall not be discovered or published. Nothing in this caveat will prohibit this authorization from including the fact that the Individual has AIDS. **For residents of Vermont:** this authorization excludes the release of any information about previously administered tests for HIV antibodies, T-cell counts, AIDS or ARC. The Individual is NOT authorizing Assurity to forward the results from any new test requested by Assurity to any outside, non-affiliated company or any entity not under specific contract to perform underwriting services.
- Information on diagnosis and treatment for alcohol, drug and tobacco use, and mental illness. Excluded are psychotherapy notes, but included are medication prescription and monitoring, counseling session start and stop times, the modalities and frequencies of treatment furnished, results of clinical tests and any summary of the following items: diagnosis, functional status, treatment plan, symptoms, prognosis and progress to date.
- Information provided on applications to obtain driving records and credit information. The records obtained will be used to determine eligibility for insurance, including additional coverage to an existing policy. I authorize the release of any information contained in credit reports and driving records, including but not limited to information on motor vehicle accidents and/or violations.

I understand that this information may be released by Assurity and/or its reinsurers to their consulting physicians, their attorneys, the MIB and to other insurance companies in which the Individual has policies or to whom applications may be made, or to whom claims for benefits have been made or may be submitted.

By my signature below, I acknowledge that any agreements I have made to restrict protected health information of the Individual do not apply to this authorization, and I instruct any licensed physician, medical practitioner, hospital, clinic, pharmacy or pharmacy benefit manager, records custodians, other medical or medically related facility, insurance or reinsurance company, the Medical Information Bureau (*MIB*), consumer reporting agency, employer or medical organization or person that has any records or knowledge of the Individual or their health to release and disclose the Individual's entire medical record as described above without restriction. The medical information so acquired will be used to determine eligibility for insurance, including additional coverage to an existing policy and/or eligibility for benefits under a policy. I understand that this information may be subject to re-disclosure by Assurity and may no longer be protected by the federal rules governing privacy of health information, and that this information may only be redisclosed in accordance with other applicable laws or regulations.

This authorization is valid for twenty-four (*24*) months from the date of signature below (**Except for residents of Arizona, authorization to disclose HIV-related information is valid for 180 days from the date of the signature below**), for collecting information in connection with an application for an insurance policy, policy reinstatement or claim. A copy of this authorization is as valid as the original. I understand that I, or my authorized representative, will receive a copy of this authorization if requested. I understand that I have the right to revoke this authorization at any time by providing written notice to Assurity. I understand that a revocation is not effective to the extent that action has been taken in reliance on this authorization. I further understand that if I refuse to sign this authorization, Assurity may not be able to process this application, or if coverage has been issued, may not be able to make any benefit payments.

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Signature of Additional Applicant/Insured/Claimant or Legal Representative

Signature of Applicant/Insured/Claimant Child (if age 18 or older)

Description of Legal Representative's Authority for Applicant/Insured/Claimant (please indicate which Individual is represented)



CONDITIONAL RECEIPT
Please Read Carefully!

TERMS AND CONDITIONS - Coverage issued bearing the date of this receipt will become effective on

- the later of the date of the application; or
- the date of completion of Part 2 – Critical Illness Section of the application; or
- the date of completion of the last medical requirements or tests required.

Coverage will be provided when the following conditions are met:

1. The application and complete evidence of insurability is received at our Home Office.
2. The Proposed Insured for coverage is insurable at standard rates exactly as applied for according to the rules and practices of the Company at its Home Office.
3. The full first premium is paid on the date of application. The maximum amount of critical illness insurance, which will become effective under this receipt, will be the lesser of the amount of insurance applied for or \$50,000. This includes any pending critical illness insurance with Assurity Life Insurance Company.

If any check, draft, money-order or other instrument tendered in payment of the amount specified hereof is not paid or honored, the said amount shall be considered unpaid and this receipt and acknowledgement of payment shall be null and void.

No conditional receipt coverage will have been in effect if any of the following apply:

- a) the application is declined; or
- b) the full first premium has not been paid; or
- c) the policy is not issued exactly as applied for; or
- d) there is insufficient evidence of insurability; or
- e) the application is not approved within sixty days of its completion.

Any premium paid and not used to issue a policy of Critical Illness Insurance will be returned. No agent of our Company has the authority to change or modify any of the provisions of this receipt.

ASSURITY LIFE INSURANCE COMPANY

PLAN _____ Amount \$ _____

ALL PREMIUM CHECKS MUST BE PAYABLE TO THE COMPANY
DO NOT MAKE CHECKS PAYABLE TO THE AGENT OR LEAVE THE PAYEE BLANK

Agent's Signature

Date: _____

I agree to the terms of the Conditional Receipt set out above.

Signature of the Proposed Insured

Date: _____

Signature of the Owner (if other than Proposed Insured)



MIB Pre-Notice

Information regarding your insurability will be treated as confidential. Assurity or its reinsurers may, however, make a brief report thereon to the MIB Inc., formerly known as the Medical Information Bureau, a non-profit membership organization of insurance companies, which operates an information exchange on behalf of its members. If you apply to another MIB member company for life or health insurance coverage or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information about you in its file.

Upon receipt of a request from you, MIB will arrange disclosure of any information in your file. Please contact MIB at (866) 692-6901 (TTY 866-346-3642). If you question the accuracy of the information in MIB's file, you may contact MIB to seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of the MIB's information office is 50 Braintree Hill Park, Ste. 400, Braintree, MA 02184-8734.

Assurity, or its reinsurers, may also release information from its file to other insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted. Information for consumers about MIB may be obtained on its Web site at www.mib.com.

Insurance Information Practices

To issue an insurance policy, we need to obtain information about you. Some of that information will come from you, and some will come from other sources. This information may in certain circumstances be disclosed to third parties without your specific authorization as permitted or required by law. You have the right to access and correct this information, except information that relates to a claim or a civil or criminal proceeding.

Upon your written request, Assurity will provide you with a more detailed written notice explaining the types of information that may be collected, the types of sources and investigative techniques that may be used, the types of disclosures that may be made and the circumstances under which they may be made without your authorization, a description of your rights to access and correct information and the role of insurance support organizations with regard to your information.

If you desire additional information on insurance information practices, please direct your requests to Assurity Life Insurance Company, P.O. Box 82533, Lincoln, NE 68501-2533.

Fair Credit Reporting Act

Pursuant to the Federal Fair Credit Reporting Act, as amended (15 U.S.C. 1681d), notice is hereby given that, as a component of our underwriting process relating to your application for life or health insurance, Assurity Life Insurance Company (Assurity) may request an investigative consumer report that may include information about your character, general reputation, personal characteristics and mode of living, except as may be related directly or indirectly to sexual orientation.

This information may be obtained through personal interviews with your neighbors, friends, associates and others with whom you are acquainted or who may have knowledge concerning any such items of information. You have a right to request in writing, within a reasonable period of time after receiving this notice, a complete and accurate disclosure of the nature and scope of the investigation Assurity requests. Please direct this written request to Assurity Life Insurance Company, P.O. Box 82533, Lincoln, NE 68501-2533.

Upon receipt of such a request, Assurity will respond by mail within five business days.

Telephone Interview Information

Assurity may require that you complete a confidential telephone interview as a part of your application for insurance. The interview will be conducted by a trained professional and may include (*but is not limited to*) the following topics: occupation, job history, income, personal and business financial information and medical history. All information obtained will be used for underwriting purposes only and will not be released without your written consent.





**BLOOD TESTING WILL INCLUDE AIDS VIRUS (HIV) ANTIBODY/ANTIGEN TESTING
APPLICATION FOR LIFE OR DISABILITY INCOME INSURANCE**

INSURER: Assurity Life Insurance Company • P.O. Box 82533 • 1526 K Street • Lincoln, Nebraska 68501-2533

To determine your insurability, the Insurer named above has requested that you provide a sample of your blood for testing and analysis. All tests will be performed by a licensed laboratory.

The consent you give by signing this form authorizes the Insurer to withdraw blood and order laboratory tests only in regard to your present application for life or disability income insurance.

The test or tests to be performed are used to determine the presence of antibodies or antigens to the Human Immunodeficiency Virus (*HIV*), also known as the AIDS virus. The HIV antibody test that we perform is actually a series of tests done by a medically accepted procedure. The HIV antigen test directly identifies AIDS viral particles. These tests are extremely reliable.

TESTS TO BE PERFORMED

We will use an ELISA test or a Western Blot Assay, or both.

An ELISA test is an enzyme-linked immunosorbent assay serologic test which has been licensed by the Federal Food and Drug Administration to detect antibodies to the human immunodeficiency virus. A positive ELISA test means an ELISA test performed in accordance with the manufacturer's specifications which is reactive on an initial testing and on at least one of two additional tests of the same serum or plasma specimen.

A Western Blot Assay is an assay which uses reagents consisting of HIV antigens separated by polyacrylamide-gel electrophoresis and then transferred to nitro-cellulose paper to detect antibodies to the human immunodeficiency virus. A reactive Western Blot Assay is a Western Blot Assay which is reactive according to the standards of performance and results specified in the manufacturer's Federal Food and Drug Administration approved product circular for the Western Blot Assay reagents and laboratory apparatus.

MEANING OF POSITIVE TEST RESULTS

Positive HIV antibody/antigen test results do not mean that you have AIDS, but that you are at significantly increased risk of developing AIDS or AIDS-related conditions. Federal authorities say that persons who are HIV antibody/antigen-positive should be considered infected with the AIDS virus and capable of infecting others.

Positive HIV antibody or antigen test results or other significant blood abnormalities will adversely affect your application for insurance. This means that your application may be declined, that an increased premium may be charged, or that other policy changes may be necessary.

CONFIDENTIALITY OF TEST RESULTS

All test results will be treated confidentially. They will be reported by the laboratory to the Insurer. When necessary for business reasons in connection with insurance you have or have applied for with the Insurer, the Insurer may disclose test results to others involved solely in the underwriting process such as its affiliates, reinsurers, employees or contractors. If the Insurer is a member of the Medical Information Bureau (*MIB, Inc.*), and if the test results for HIV antibodies/antigens are other than normal, the Insurer will report to the MIB, Inc. a generic code which signifies only a nonspecific blood test abnormality. If your HIV test is normal, no report will be made about it to the MIB, Inc. The organizations described in this paragraph may maintain the test results in a file or data bank. There will be no other disclosure of test results or even that the tests have been done except as may be required or permitted by law or authorized by you.

COST OF TESTING

The cost of any testing will be borne by the Insurer.

NOTIFICATION OF TEST RESULTS

If your HIV test results are normal, no routine notification will be sent to you. If the HIV test results are other than normal, the Insurer will contact your designated physician, or you if you have not designated a physician, the Insurer will ask you for the name of a physician or other health care provider to whom you may authorize disclosure and with whom you may wish to discuss the results.



TIME LIMIT

This Consent shall be valid for a period of 30 months from the date noted below.

CONSENT

I have read and I understand this Notice of Consent for Blood Testing Which Will Include HIV Antibody/Antigen Testing. I voluntarily consent to the withdrawal of blood from me by needle, the testing of that blood and the disclosure of the test results as described above.

In the event of a positive HIV test result, I authorize Assurity Life to send the test results to the following health care professional:

Physician's Name _____

Physician's Address _____

I understand that I have the right to request and receive a copy of this authorization. A photocopy of this form will be as valid as the original.

Proposed Insured (Printed) _____
Date of Birth (MM/DD/YYYY)

Signature of Proposed Insured or Parent/Guardian _____
Date (MM/DD/YYYY) _____
State of Residence



COUNSELING RESOURCES LIST

Public health authorities urge that everyone become educated about how to protect themselves from HIV infection. If you have questions or concerns, your own physician or health care provider is your best source of information. Other counseling services may also be available to you.

As required by California law, the following list of counseling resources is being provided to you. It was compiled from publicly available information, which is subject to change without notice to Assurity Life Insurance Company Therefore, Assurity Life makes no representations or warranties that this information is accurate as of the date you receive this list. Also, Assurity Life makes no representations or warranties about the quality or nature of any services these resources may provide.

This is not a complete list of all resources that may be available to you. We suggest you contact your own physician or health care provider, your county health department or your local chapter of the American Red Cross for further information.

AIDS HOTLINE-U.S. PUBLIC HEALTH SERVICE
800-342-AIDS

SPANISH AIDS HOTLINE
808-344-7432

TTY INFORMATION
Information and Referral for Hearing Impaired
213-464-0029

SANTA CLARA COUNTY ARIS PROJECT
Campbell
408-370-3272

AIDS HOTLINE-SOUTHERN CALIFORNIA
800-922-AIDS

SONOMA COUNTY AIDS INFORMATION HOTLINE
707-579-AIDS

KERN COUNTY AIDS TEAM
Bakersfield
805-861-3631

AIDS PROJECT-EAST BAY
Oakland
415-420-8181

SACRAMENTO AIDS FOUNDATION
Sacramento
916-448-2437

CENTRAL VALLEY AIDS TEAM
Fresno
209-264-2436

SAN FRANCISCO AIDS FOUNDATION
San Francisco
415-846-5855

AIDS SERVICES FOUNDATION OF ORANGE COUNTY
Costa Mesa
714-646-0411

AIDS PROJECT-LOS ANGELES
West Hollywood
213-876-8951

INLAND AIDS PROJECT
Riverside/San Bernardino Counties
714-784-2437

SAN DIEGO AIDS PROJECT
619-543-0300-City of San Diego
619-945-6000-City of Vista

SANTA BARBARA COUNTY AIDS HOTLINE
805-965-2925

CALIFORNIA DEPARTMENT OF HEALTH SERVICES
Statewide Services
Office of AIDS-Sacramento
916-323-7415

HEMOPHILIA FOUNDATION OF SOUTHERN CALIFORNIA
Social Services-Southern California
Hemophilia AIDS Information
818-792-6192
714-740-2222

SHASTA COUNTY HELPLINE
916-225-5252



